Petition – Personal Home Care of NC, LLC
Received Regarding the Proposed 2007 State Medical Facilities Plan

Attached are:

1. Agency Analysis on the Petition

2. Petition from Personal Home Care of NC, LLC and comments from March 1, 2006 Public Hearing

AGENCY Analysis:

Proposed 2007 Plan

- Notes related to **Home Health Petition** from **Personal Home Care of NC, LLC**

Request

Personal Home Care of NC, LLC submitted a Petition requesting the following change to the Home Health methodology:

> "a. Where the cumulative home health agency patient need in a region is greater than 225 and a single county in the region has a need greater than 200 but less than 400, and a petitioner has demonstrated that a substantial population of the region has its access to home health restricted by virtue of a language barrier, the need shall be adjusted to include one home health agency to serve at least three counties in which such a language barrier to access can be demonstrated."

The petitioner also requested a new Home Health Policy as follows:

> "a. HH-4 When the two critical factors prevail and a petitioner can demonstrate that the region has no agency staffed by nurses and therapists who are fluent in a language spoken by a significant underserved population, the State Medical Facilities Plan for the following year should be adjusted to make a provision for a home health agency that would staff with nurses and therapists who are fluent in that language and would serve that planning region. The factors are:
>
> i. The planning region has a significant population who speak a language other than English or Spanish, and
>
> ii. The home health agency patient need in the region is at least 225."

Background Information

The home health need methodology projects future need based on trends in historical data, including the "Average Annual Rate of Change in Number of Home Health Patients" over the previous three years and the "Average Annual Rate of Change in Use Rates per 1000 Population" over the previous three years. Average annual rates of change are compiled based on "Council of Governments (COG)" regions.

Patient origin data used in the Plan is compiled from Home Health Agency Annual Data Supplements to License Applications as submitted to the Division of Facility Services. The data supplements request data for a twelve month period using a start date of either July, August, September or October. The methodology aggregates patient origin data by four age groups, 0-17, 18-64, 65-74 and over 75.

The methodology utilized in development of the State Medical Facilities Plan does not project future need based on the number of home health agencies in any given county or on the capacity of existing agencies. Rather, it projects need based on the number of patients served

during the reporting years indicated in the plan. In essence, if existing agencies keep pace with the projected number of persons who may need home health services, there would not be a need determination. However, if they do not keep pace, there may be a need determination allowing an opportunity for a new home health agency or office.

The basic methodology utilized in the 2006 Plan was first used in the1996 Plan. The first year a need determination was made based on the standard methodology was in the Proposed 2004 Plan. However, there was an adjusted determination of no need for additional home health agencies/offices in the 2004 Plan. The adjustment was made in light of the Task Force to study the home health need determination methodology.

A twelve member Task Force was formed and made recommendations to the State Health Coordinating Council. A change to the standard methodology recommended by the Task Force was to raise the deficit threshold for a need determination from 250 patients to 400 patients. The recommendation was accepted and incorporated into the methodology for the Proposed 2005 Plan. Application of the new methodology resulted in a need determination for Mecklenburg County in the 2005 Plan. Eight applications were received for the need determination. The petitioner was not one of the applicants.

There is one Home Health policy in the 2006 Plan. The policy allows for a need determination for a Medicare-Certified home health agency under defined conditions. This policy was recommended by the Task Force discussed in the above paragraph.

Staff provided the petition for comment to the Association for Home and Hospice Care of North Carolina. Attached are comments received from the Association.

ANALYSIS OF PETITION

The petitioner appears to be proposing criteria by which a petitioner would be evaluated to determine if there would be an adjusted need determination for a new Medicare-certified home health agency in a region. It does not appear to be necessary to change the methodology or adopt a new policy when the methodology and policy would require a petition to be filed to create a need determination. A person can petition for adjusted need determinations without such a methodology change or policy. Further, if there were to be a need determination, there is no guarantee that the petitioner would be the approved certificate of need applicant.

If the methodology changes and the policy proposed by the petitioner were to be adopted, there are several points that should be clarified. These include: What is a region? Can a region include non-contiguous counties? How large can a region be? What is the measure of "substantial population"? What is the measure of fluency in a language? What is the measure of a "significant underserved population? What plan would be used as the basis for determining cumulative home health agency patient need in a region - the Proposed Plan or the current year's Plan? Further, a cumulative need in a region of 225 is approximately 44% less than the current standard methodology's need determination threshold of 400 patients.

The petitioner cites Mecklenburg, Union and Cabarrus counties as an area with a large population of Russian speaking immigrants. The 2006 Plan indicates a projected surplus of

48 patients in Mecklenburg County and deficits of 219 patients in Union County and 70 patients in Cabarrus County. This results in a cumulative deficit of 241 patients.

The petitioner also cites the Research Triangle area of North Carolina. The 2006 Plan indicates a deficit of 359 patients in Wake County and surpluses of 62 patients in Durham County and 3 patients in Orange County. This results in a cumulative deficit of 294 patients.

The petitioner states that no home health agency in Charlotte has Russian-speaking staff. However, that does not preclude an agency from having such staff in the future.

The petitioner states that there may not be another need determination in the Greater Charlotte Area for another year or more. However, even if a need determination was identified in the 2007 Plan, it could be a year or more before a certificate of need were issued.

It is not clear how the petitioner determined, "*Without an agency staffed by Russian-speaking nurses and therapists, approximately 400 persons in the greater Mecklenburg area today have no or inadequate access to home health agency care.*" The petitioner indicates that more than 15 patients it serves today qualify for home health agency nursing services.

In response to a need determination in the 2005 Plan, Certificate of Need has conditionally approved development of a new Medicare-Certified home health agency in Mecklenburg County. That agency has yet to be licensed and certified. Based on the standard methodology, a place-holder will be applied for Mecklenburg County through the three annual plans following certification of the agency.

If the petition was to be approved and there was a need determination based on application of the new methodology and policy, it is presumed that there would be a placeholder created for the new agency. Such a placeholder could prevent there being a need determination based on the standard methodology for the community as a whole.

If this petition were to be approved, it is not known to what extent others may propose similar petitions in the future to address specific population groups.

Alternatives that may be considered:

1. Purchase an existing Medicare-Certified home health agency. Such a purchase is exempt from obtaining a certificate of need if the Certificate of Need Section receives prior written notice from the entity proposing the acquisition.
2. Apply for a certificate of need when a need determination is identified in the State Medical Facilities Plan for a county of interest to the petitioner.
3. Explore sub-contracting with an existing Medicare-Certified agency to provide services to the target population. The petitioner identifies subcontracting or a joint venture with an existing home health agency as a compelling concept. While the petitioner cites reasons for not doing so, it appears that this could be an alternative to development of a new agency in an area that already has multiple existing agencies providing services. It appears that there would be costs associated with translation regardless of who owns or operates the agency that is providing services.

Agency Recommendation

The Agency supports the home health standard methodology and policy as presented in the 2006 Plan. The Agency recommends that the petition be denied.

Association for
Home & Hospice Care
of North Carolina

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April 4, 2006

Floyd Cogley, Planner
DHHS-Medical Facilities Planning Section
Division of Facility Services
2701 Mail Service Center
Raleigh, North Carolina 27609-2701

Re: Personal Home Care of NC Petition – Change in HH Methodology and Policies

Dear Floyd and LTC Committee members:

Thank you for the opportunity to comment on the petition by Personal Home Care of NC to change the home health methodology and polices.

After careful review, the Association for Home and Hospice Care of North Carolina **opposes** the petition for the following reasons. Please allow me to illustrate:

1. AHHC is one of the nations oldest and the largest home health trade groups representing Medicare and Medicaid certified home health agencies. 96% of North Carolina's home health agencies are members.
2. The SHCC convened in 2004 a large and diverse Home Health Methodology Task Force which met and made substantive recommendations to the SMFP. These changes were adopted by the SHCC and incorporated in the current SMFP. The task force recommendations were the first major changes to the SMFP since the 1996 SMFP and are only in their second year of implementation.
3. The Petitioner chose the route of petitioning the SHCC for a major change in home health methodology and policies rather than the route of a special needs petition and in essence could have major statewide implications. The petitioner claims that Russian speaking home health patients, five times greater than what the US census Bureau claims, reside in Mecklenburg county and due to language barriers are either not served or underserved by existing home health agencies. While AHHC is sympathetic to any group claiming itself to be underserved, an overhauling change in current methodology is not the answer.
4. 19 home health agencies currently serve this county with a new CON (from last year's Plan) under review for certification. AHHC has been in contact with some existing agencies and have found no reports of Russian speaking citizens being denied services due to a difference in language. AHHC encourages agencies to utilize an existing array of translator services

whenever a language barrier is present and/or staff is not fluent.

5. The petition would allow for a major reduction in patient need to trigger a new home health agency CON due to a perceived language barrier and an allowance to serve up to three counties. Home health agency CON's are granted on a county by county basis of need and service area is not determined by CON but rather by existing CMS law and rules as well as an agency's operational and staffing ability. Both sections A and B of the petition while having statewide implications could set dangerous precedent in all settings of care not just home health and may not be in conformance with state and federal rule. Also, much of this petition is speculation and estimates and lacks hard, credible and studied data.
6. While AHHC is sympathetic to a special need such as language barrier, we would support a better collaborative effort with the 19 existing agencies and the community in question. AHHC would advocate within the industry a stronger relationship with not only the Russian community but other minorities as well.
7. For all of the above reasons, we respectfully ask that the Committee **OPPOSE** the petition.

Thank you again for this opportunity. We would be happy to work with this petitioner and any other agency in strengthening relationships with the certified home health agency community.

Cordially,

Jim Rogers

Timothy R. Rogers, EVP
Association for Home and Hospice Care of NC

MARCH 1, 2006
PUBLIC HEARING

Good morning and thank you. My name is Ivans Belovs and I a co-owner of the Personal Home Care of North Carolina agency, a home care provider in Charlotte, NC. We have prepared a formal petition, which was submitted today, asking for a change in home health methodology and policy to permit development of a home health agency whose purpose is to serve the large Russian-speaking community in the Mecklenburg and surrounding counties.

I came to the USA from Latvia, former Soviet Union, in 1997 as a professional hockey player. After retiring, I settled in Charlotte. I started a Russian language newspaper, Panorama Charlotte, and became active in Russian community. We've received plenty of phone calls asking for assistance with daily life and a major number of them related to the health care. When my father-in-law became ill and I saw the problems he was having with communicating with nurses and other professionals taking care of him at home, I realized that language difficulties were presenting major problems for large number of Russian-speaking people in our community. Through mutual friends, I was introduced to Dr. Yanna Rachinskaya, who established a personal home care agency to address this issue in Baltimore, MD. We decided to give this idea a try and two years ago we founded Personal Home Care of North Carolina, LLC. 90% of people we serve speak Russian. They speak little or no English. As we have developed our business, which is limited to in-home aides and nurse monitoring, we found out that our clients need nursing care and that requires a home health agency.

Today, no home health agency in Charlotte area has Russian-speaking staff. Two, Carolinas Medical Center and Presbyterian, have contracts with translation agencies , but the interpreter's schedule do not always match the schedule of the patient, particularly when the call occurs at night. Too often, the patients are calling on our staff to come in as volunteers to do interpretation. We cannot keep up.

You may be surprised but the local Russian community is large – we estimate approximately 50,000.

Without a home health agency staffed by people who speak Russian, many people are trapped in their homes, unable to get access to the Medicare and Medicaid services for which they are eligible. They are legal immigrants, many of them are citizens, they and their children pay taxes but the clients do not get the benefit or their taxes. These older people are not going to learn English now; their daily struggle to survive takes all of their energy.

The Community Alternatives Program agencies in Mecklenburg and Union counties, with whom we have contracts, suggested that we should expand our services and become a home health agency. But we found that State Medical Facilities Plan has no need, so we cannot apply. We have letters of support from both agencies. Today we are asking you for change in the Plan to give us an opportunity to apply so that we can give these people the services they need. We are willing to work with you through this process and realize that you may be skeptical of the need. We are ready to show you that it exists.

MARCH 1, 2006
PUBLIC HEARING

My partner, Yanna, is going to talk a little about the size of the need.

Good morning. I am Yanna Rachinskaya and I am also a co-owner of Personal Home Care of North Carolina. As Ivan mentioned before, I established a personal care agency in Baltimore, MD, and a home health agency in Dallas, TX to serve the Russian-speaking population.

I am somewhat familiar with the planning process and would like you to know that we are prepared to work with you in any way you want. I also understand your need for numbers. I have a doctorate in Public Health and a background in clinical research so, believe me, I do not underestimate the significance of statistical data.

While preparing the petition, I've contacted many demographic resources trying to get you an estimate of the Russian-speaking community in Charlotte. We knew that it is large but nobody could give us a concrete number. We got in touch with the resettlement agencies, HIAS and local churches but the common response was "There is no reliable data." We contracted Migliara Kaplan Marketing Research Institute trying to establish a model that might render us numbers but, unfortunately, primary language is not one of the criteria measured by census.

Although the size of Russian-speaking community in greater Charlotte area is estimate, the need is very real. We work with them, we are them, we speak the language and have similar background, we serve them as volunteers and doing our best to help them. However, we would like to turn the services into something that is sustainable in the long run and that can reach beyond what our meager volunteer resources can support.

Thank you for your time. We are willing to answer any questions you may have.

Petition to the State Health Coordinating Council
Regarding the Home Health Methodology and Policies
For the 2007 State Medical Facilities Plan

Petitioner:

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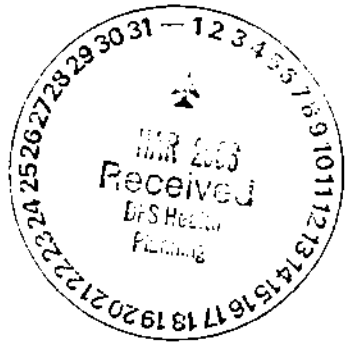
Charlotte, NC 28211

Contact:

Ivans Belovs
Personal Home Care of NC, LLC
704-975-5253



PETITION

STATEMENT OF REQUESTED CHANGE

Personal Home Care of NC requests the following changes in the methodology and policies for the 2007 State Medical Facilities Plan.

(A) The methodology would change as follows:

a. Where the cumulative home health agency patient need in a region is greater than 225 and a single county in the region has a need greater than 200 but less than 400, and a petitioner has demonstrated that a substantial population of the region has its access to home health restricted by virtue of a language barrier, the need shall be adjusted to include one home health agency to serve at least three counties in which such a language barrier to access can be demonstrated.

(B) The policy would change as follows:

a. **HH-4** When the two critical factors prevail and a petitioner can demonstrate that the region has no agency staffed by nurses and therapists who are fluent in a language spoken by a significant underserved population, the State Medical Facilities Plan for the following year should be adjusted to make a provision for a home health agency that would staff with nurses and therapists who are fluent in that language and would serve that planning region. The factors are:

   i. The planning region has a significant population who speak a language other than English or Spanish, and

ii. the home health agency patient need in the region is at least 225.

REASONS FOR THE PROPOSED CHANGES

The greater Mecklenburg area, including Mecklenburg, Union and Cabarrus counties has attracted a large population of Russian speaking immigrants. They initially settled here in the early 1980's and their numbers grew following the collapse of the former Soviet Union in 1990's. Mecklenburg County had an immigration policy that favored it as a destination for refugee immigrants. Churches and other religious institutions, including Baptist and Jewish congregations had long-standing relationships with religious groups that were facing oppression in the countries that made up the former USSR, like Ukraine, Russia, Armenia, Azerbaijan, Byelorussia, Latvia, and some countries of Eastern Europe. The churches provided these refugees with resettlement assistance. The Hebrew Immigrant Aide Society, which has expanded its role far beyond the original mission of resettlement of Holocaust survivors, helped to settle the first groups in the area. Baptist Missions and other Christian sects followed suit. In 1999, the US Congress passed a law, the Russian Leadership program (PL 106-31) to improve understandings of the Russian culture in the US. The NC Courts have added Russian to the list of languages for which it will provide interpreters.

In Greater Mecklenburg, communities, businesses and churches formed in the 1980's. In the 2000's the established communities began to attract immigration from other Russian-speaking groups in the larger US cities: Seattle, Los Angeles, New York and Chicago. These are legal immigrants. They are entitled to Medicare and Medicaid. Many have become citizens. The younger people have started businesses here and have become employers and taxpayers. The Russian-speaking immigrants come from a culture of strong family ties; as a result, they come into the state as large groups of relatives, 20 and 30 together. The older generation does not speak English. Russian is also a difficult language for English-speakers as it uses a different alphabet and different structures. The culture is different and direct translation does not always communicate the intended meaning.

Measuring the number of residents in these communities is very difficult. Census data are by the Bureau's admission, unreliable. There is no check-off on the census form to indicate Russian-speaking. At best, the census estimates ancestry. To estimate the size of the Russian-speaking community, we have approached city and county governments, the Census internet sites, private companies that specialize in demographic profiles such as Migliara Kaplan, and refugees' resettlement agencies. From each we received the same answer, "There are no reliable data." The US Census report of 4,109 Russian-speaking residents in North Carolina in 2000 is clearly an underestimate. We know. Mecklenburg's Russian language newspaper, Panorama Charlotte, which is printed in Russian, distributes over 10,000 copies monthly. Each of these is shared at least five times, putting the estimate at 50,000 people. Church attendance at Russian speaking services in Charlotte alone is estimated at 10,000 weekly. Russian businesses in Charlotte alone number 73. As a proxy measure of the breadth of the Russian speaking population, we have assembled the attached list of Russian businesses.

Russian churches, and letters from the Mecklenburg CAP agency that contracts with Personal Home Care of NC to provide in-home aide care to Medicaid beneficiaries.

We are acutely aware of their presence in large numbers, because we serve them. We are part of them. Today, we are providing in-home nursing visits to these people at no charge, because we cannot offer them the Medicare benefit. At the same time, they cannot get full care from existing home health agencies.

Home Health is a Medicare and Medicaid core service, but home health agency care requires communication between patient and caregiver. All of the services occur in the patient's home, where a caregiver is on his/her own to make judgments and leave instructions. The premise of home health agency care is that the care provider can instruct the patient and/or family caregiver in continued maintenance of the care regimen after the home health agency eligibility expires. When language is a barrier for both provider and patient, this cannot occur.

Let me illustrate with the story of Ivan and his wife, Leda, who is his caregiver. He has prostate cancer, and was enrolled in the CAP program with Personal Home Care. Neither can converse in English. In-home aides from Personal Care were not enough to provide all of the care, for he has an imbedded urine catheter and needs nursing care. Home health agency nurses were sent to their home. The nurses spoke only English and did not understand Ivan's complaints. The tried, but changing the catheter became very painful for Ivan, who could not explain the cause or location of his agony. Because Leda knew Ivans Belovs from Personal Care from her CAP experience, she called him in despair and asked for assistance. Ivans went to the house as a volunteer interpreter; and with his help and sign language Ivans was able to get the home health agency nurses to show Luda how to do catheter cleaning and changes. After that, the home health agency nurses came to leave supplies and take blood pressures, but were unable to communicate any care changes that might have been helpful to Ivan or Luda. This awkward arrangement eventually resulted in having Ivan discharged. Now he is in a hospice. Language remains a problem. Desperate to find help, hospice volunteer appealed to community at large via the internet, calling for Russian speaking volunteers to come to the home to help with interpretation so that Ivan could stay at home. Home heath could not help, because Luda could not communicate with them. Because they refuse to let him go to an institution, Ivan is at home. A hospice agency sends nurses to deliver supplies, but they are unable to help with true end of life or palliative care. Ivan and Luda continue to struggle in the prison of their language isolation, with their dignity compromised.

More than fifteen patients served by the Personal Home Care of NC through the CAP program qualify for home health agency nursing services today. However, Personal Home Care of NC cannot provide home health agency care, because we do not have a home health agency license. Mecklenburg's CAP agency continues to refer the patients to Personal Home Care because Personal Home Care is the only Russian-speaking service in the area. Personal Home Care is providing nursing service to all of them without getting compensated, because patients have no other care alternative. This is not sustainable for long. Without a home health agency, we cannot provide a full continuum of care for these patients.

The CAP agency has suggested that we get a home health agency license. Yet, the State Medical Facilities Plan has such high need thresholds before it permits new home health agencies in a county that we are not likely to have an opportunity to apply for a CON for the Greater Charlotte Area for another year or more. Yet the Russian community is still growing and the older generation is getting still older.

The Hispanic population represent 8 to 15 percent of the North Carolina regional economy and for them service providers have made adjustments , adding in house bilingual staff and training materials for many residents who are illegal. By contrast, the legal Russian population is still an underserved and often un-served minority. Home health agency services are intended to be of short duration, usually one month or less, with each visit lasting about one hour. They are built on the premise that health care providers will involve family caregivers in an education program that involves training in continued care of the patient. When language is a barrier, this critical service element cannot occur. As a result, the patient usually drops out of the service, frustrated by both sides' inability to communicate. Consequently, patients are not getting services to which they are entitled by law.

Prior to submitting this application, we, Personal Care of North Carolina, checked with every home health agency that serves Mecklenburg County. Not one had a Russian-speaking nurse on the payroll. Two, Carolinas Medical Center and Presbyterian, had contracts with interpreter services. The interpreter service as an alternative is better than nothing. However, the Russian interpreters are too few to accommodate multiple home health agency visits occurring at the same time, and many are not available to cover night visits.

On the positive side, the Russian population in the greater Mecklenburg area has reached sufficient size to support home health agency services. It is already supporting a CAP agency that serves very sick Medicaid patients, keeping them out of institutions. The Mecklenburg County CAP coordinator reports that in an average home health agency, CAP patients represent about 15 percent of patients. At this ratio (6.7 home health agency patients per CAP patient or 100/15) Personal Home Care, with 60 CAP patients could support 400 home health agency patients.

In designing the proposed methodology, we intentionally set the threshold high, at 225 patients in a region. By doing so, the Plan will have built-in assurance that the need for home health agency patients is sufficient to insure the success of the new agency, yet cause minimal impact on existing providers. In the end, the burden of proof will be upon the applicant.

ADVERSE EFFECTS ON PROVIDERS AND CONSUMERS OF NOT MAKING THE REQUESTED CHANGE

Expanding Health Care Services to the Medically Underserved is one of the three basic principles of the State Medical Facilities Plan.

Without an agency staffed by Russian-speaking nurses and therapists, approximately 400 persons in the greater Mecklenburg area today have no or inadequate access to home health agency care. This is a significant number and is the number used by the 2006 SMFP to determine need for a new home health agency in a single county. This need spans three contiguous counties, that the petitioner has demonstrated capacity to serve, Mecklenburg, Cabarrus and Union.

The Russian speaking population is dynamic, growing daily, as part of the 38,000 and growing new residents that, as the Chamber of Commerce reports, are pouring into the greater Mecklenburg area every year. Russian and English languages are very different in structure; literal translations and interpretations do not reflect comparable meanings. Hence non-medical interpreters and translators cannot bridge the gap.

Not to act is to deprive a large population that intends to stay out of institutions of the care needed to support them at home. A day of home health agency service is far less expensive than a day in a skilled nursing care facility. More importantly, the home health agency care regimen is designed to make the patient independent in a month or two, whereas, once placed in a nursing home, a patient tends to stay about three years.

ALTERNATIVES TO THE REQUESTED CHANGE CONSIDERED AND REJECTED

Personal Home Care of NC, LLC, considered several alternatives, including: 1) status quo; 2) subcontracting with an existing home health agency to specialize in provision of home health services to Russian-speakers Home Health and 3) this petition. This petition is the result of two years of unsuccessfully trying the other two alternatives.

We are living the status quo. Patients are calling Personal Home Care of NC, LLC when they have a medication or wound care crisis. Unwilling to cause families and patients undue suffering, Personal Care has been providing free home visits. This is not sustainable. PHC has tried getting the patients into area home health agencies, only to have the service fail because of the communication problems.

Working a subcontract or joint venture with other agencies to hire Russian speaking staff is a very compelling concept. However, the additional administrative structure this will require will reduce the funds available for patient care. The same translation difficulties that now occur between patient and caregiver will only shift to the arena of caregiver and administrator. This arrangement would eliminate from the labor pool any nurses whose primary fluency is in Russian, because it will require bi-lingual nurses to handle the administrative translations and interpretations. At a time when nurses are in short supply, and efforts to control health care costs abound, this would not provide a durable solution.

PHC also considered setting the threshold lower than 225 patients. At this level, the 2006 SMFP would support only two agencies, one in the Research Triangle area, and one the Greater Mecklenburg area. These two communities are the fastest growing in the state and are more likely to support an ethnic sub-culture. We believe in starting small to demonstrate the value of this approach. As demonstrated in the following table, these populations are sufficiently large to support diversified agencies.

State Demographer Population Estimates

County	Apr-00	Jul-05	Apr-10	Jul-15	Apr-20	Jul-25	Apr-30
MECKLENBURG	695,370	786,651	880,879	981,358	1,082,890	1,189,291	1,296,741
UNION	123,772	158,002	184,590	213,229	242,652	274,436	306,210
CABARRUS	131,063	150,249	168,682	188,344	209,070	230,661	253,051
	950,205	1,094,902	1,234,151	1,382,931	1,534,612	1,694,388	1,856,002
Change from 2005			139,249	288,029	439,710	599,486	761,100
WAKE	627,866	746,336	859,649	981,999	1,106,218	1,236,514	1,367,176
Change from 2005			113,313	235,663	359,882	490,178	620,840

source: http:// demog.state.nc.us

NON-DUPLICATION OF SERVICES

This proposed change requires an applicant for the CON to demonstrate that the population in need is sufficient in size to support a home health agency and that the population is not getting adequate care. A small and diversified home health agency can be viable with 200 patients. Consequently, there will be no duplication of services. The suggestion to develop a home health agency came from one of the CAP agencies that saw the need to complete the continuum of care. The CAP agency would have no interest in developing duplicative services.

The proposal would add home health agency services only in two very rapidly growing parts of the state

CONCLUSION

Personal Home Care of NC, LLC, respectfully requests that the State Health Coordinating Council consider a policy that would permit development of home health agencies to serve groups of people for whom language presents a significant barrier to receiving care. Except for the CAP agency letters, all of the letters below were translated back and forth from English to Russian to English.

Attachment: Letters from CAP agencies
Letters from Churches
Letter from community group
List of Russian Businesses
List of Russian Churches
Table 12C 2006 SMFP pp 252, 253
Census Facts 2004 Russian Ancestry Mecklenburg County Households.

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UNION COUNTY DEPARTMENT OF SOCIAL SERVICES
P.O. BOX 489
MONROE, NORTH CAROLINA 28111

Margaret Hood, Chairman
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Roy A. Young, *Director*

AN ACCREDITED AGENCY

February 21, 2006

State Health Coordinating Council
c/o Floyd Cogley
Division of Facility Services
2714 Mail Service Center
Raleigh, North Carolina 27699-2714

Dear Committee Members,

Personal Home Care of North Carolina agency plays an important and unusual role in the greater Mecklenburg community area. This agency emerged in response to a unique problem and is providing very responsive services to a large community that is difficult to serve. We have become a center for Russian-speaking immigrants from the republics of the former USSR, Ukraine, Byelorussia, and other countries. The communities began forming in the late 1980's and continue to grow as people settle. Entire extended families are appearing in the area. This means that the parents, grandparents and older relatives come along with the younger ones.

The older people do not speak English, or if they do, their vocabulary is limited. They are legal immigrants; many are citizens. They are entitled to Medicare and Medicaid services, but the language and cultural barriers make it difficult for most agencies to serve them. Personal Home Care of NC organized to meet their needs. Today, the Russian-speaking patients constitute approximately 10 percent of our CAP patients. Personal Care is the only agency that does serve them, because their staff speaks Russian and understand this culture. Personal Care is helping us to keep people at home and out of the nursing home. Family members in this community are committed to this vision and assign a person to stay with the older and infirm.

This population has difficulty getting home health agency care because of the language and cultural barriers. I believe that a policy permitting the state to add a home health agency to serve a cultural group this large makes sense and would be in the interest of making heath care accessible. Given the size of the population in the CAP agency, I believe they would have enough members to support a home health agency.

Please do not hesitate to call me should you have questions.

Regards

Union County CAP Program
Jen Daniels RN Supervisor CAP/IHS

February 21, 2006

State Health Coordinating Council
c/o Floyd Cogley
Division of Facility Services
2714 Mail Service Center
Raleigh, North Carolina 27699-2714

Dear Committee Members,

Personal Home Care of North Carolina agency plays an important and unusual role in the greater Mecklenberg community area. This agency emerged in response to a unique problem and is providing very responsive services to a large community that is difficult to serve. We have become a center for Russian-speaking immigrants from the republics of the former USSR including Russia, Ukraine, Belarus, and other countries. The communities began forming in the late 1980's and continue to grow as people settle. Entire extended families are appearing in the area. This means that the parents, grandparents and older relatives come along with the younger ones.

The older people do not speak English, or if they do, their vocabulary is limited. They are legal immigrants; many are citizens. They are entitled to Medicare and Medicaid services, but the language and cultural barriers make it difficult for most agencies to serve them. Personal Home Care of NC organized to meet their needs. Today, the Russian-speaking patients constitute 8 percent of our CAP patients. Personal Care is the only agency that does serve them, because their staff speaks Russian and understand this culture. Personal Home Care of NC is helping us to keep people at home and out of the nursing home. Family members in this community are committed to this vision and assign a person to stay with the older and infirm.

This population has difficulty getting home health agency care because of the language and cultural barriers. I believe that a policy permitting the state to add a home health agency to serve a cultural group this large makes sense and would be in the interest of making heath care accessible. Given the size of the population in the CAP agency, I believe they would have enough members to support a home health agency.

Please do not hesitate to call me should you have questions.

Regards

Sue A. McCraw RN BSN

Sue McCraw

704 - 336 - 6446
Mecklenburg CAP DA Supervisor

First Slavic Baptist Church
7600 Plott Rd. Charlotte, NC 28215

February 25, 2006

State Health Coordinating Council

c/o Floyd Cogley

Division of Facility Services
2714 Mail Service Center
Raleigh, North Carolina 27699-2714

Dear Committee Members,

This letter is in support of Personal Home Care of North Carolina, LLC petition to provide home health services. Personal Home Care of North Carolina plays an important and unusual role in and around the counties of Mecklenburg, Union, and Cabarrus. This personal care agency emerged in response to a unique problem and is providing very responsive services to a large community of new Americans that is difficult to serve.

Russian speaking immigrants from the former USSR republics of Russia, Ukraine, Belarus, Armenia, Azerbaijan, and other countries represent a large part of this population. We estimate that about 80,000 of Russian-speaking people are residing in this part of state now, and their numbers are growing. The communities began forming in the late 1980's, when the State of North Carolina started admission of refugees representing ethnic and religious minorities that were persecuted in their countries, grown immensely since collapse of the Soviet Union in 1990's, and continue to grow as people settle and re-unite with their families. Entire extended families are appearing in the area. This means that the parents, grandparents and older relatives come along with the younger ones.

The older people do not speak English, or if they do, their vocabulary is very limited. They are legal immigrants and many are naturalized citizens. These individuals are often sick and disabled and entitled to Medicare and Medicaid services, but the language and cultural barriers make it difficult to happen. Family members in this community assign a person to stay with the older and infirm, but lay people cannot provide clinical services, and are not always able to act as clinical interpreters.

Personal Home Care of North Carolina was organized to meet needs of this population and. is the only agency that serves them. Personal Home Care of North Carolina staff members are bi-lingual in Russian and/or Ukrainian, have similar background and understand this culture. However, Personal Care of North Carolina is limited by licensure restrictions to the amount of service they can provide.

Elderly and disabled individuals with limited or non-existent English proficiency have difficulty getting home health agency because of the language and cultural barriers. Local agencies do not have Russian-speaking staff; therefore communication issues are paramount and care quality might become compromised. I believe that a policy permitting the state to add a home health agency to serve a cultural group this large makes sense and would be in the interest of making heath care accessible.

Our church has been fortunate to have access the limited services Personal Home Care of NC, LLC can provide for our members. Our members need more.

Please do not hesitate to call me should you have questions.

Regards,

Vasiliy Yeremuk
Senior Pastor
Phone: 704 - 568 - 9662

Baptist Church of Salvation

McKee Road Baptist Church
4300 McKee Road
Charlotte, NC 28270

(704) 201-3599
(704) 293-0100
(704) 573-9293
(530) 689-8285 Fax

February 26, 2006

State Health Coordinating Council
c/o Floyd Cogley
Division of Facility Services
2714 Mail Service Center
Raleigh, North Carolina 27699-2714

Dear Committee Members,

This letter is in support of Personal Home Care of North Carolina, LLC petition to provide home health services. Personal Home Care of North Carolina plays an important and unusual role in and around the counties of Mecklenburg, Union, and Cabarrus. This personal care agency emerged in response to a unique problem and is providing very responsive services to a large community of new Americans that is difficult to serve.

Russian speaking immigrants from the former USSR republics of Russia, Ukraine, Belarus, Armenia, Azerbaijan, and other countries represent a large part of this population. We estimate that about 80,000 of Russian-speaking people are residing in this part of state now, and their numbers are growing. The communities began forming in the late 1980's, when the State of North Carolina started admission of refugees representing ethnic and religious minorities that were persecuted in their countries, grown immensely since collapse of the Soviet Union in 1990's, and continue to grow as people settle and re-unite with their families. Entire extended families are appearing in the area. This means that the parents, grandparents and older relatives come along with the younger ones. These immigrant communities represent people of multiple faiths and ethnic origins and several churches and congregations of multiple faiths have formed: Baptist, Pentecostal, Charismatic, Christian Orthodox, Armenian Episcopalian, Jewish, and others.

The older people do not speak English, or if they do, their vocabulary is very limited. They are legal immigrants and many are naturalized citizens. These individuals are often sick and disabled and entitled to Medicare and Medicaid services, but the language and cultural barriers make it difficult to happen. Family members in this community assign a person to stay with the older and infirm, but lay people cannot provide clinical services, and are not always able to act as clinical interpreters.
Personal Home Care of North Carolina was organized to meet needs of this population and is the only agency that serves them. Personal Home Care of North Carolina staff members are bi-lingual in Russian and/or Ukrainian, have similar background and understand this culture. However, Personal Care of North Carolina is limited by licensure restrictions to the amount of service they can provide.

Elderly and disabled individuals with limited or non-existent English proficiency have difficulty getting home health agency because of the language and cultural barriers. Local agencies do not have Russian-speaking staff; therefore communication issues are paramount and care quality might become compromised. I believe that a policy permitting the state to add a home health agency to serve a cultural group this large makes sense and would be in the interest of making heath care accessible.

Our Baptist Church of Salvation has been fortunate to have access the limited services Personal Home Care of NC, LLC can provide for our members. Our members need more.

Please do not hesitate to call me should you have questions.

Regards,

Veaceslav Paskal - Pastor Vyacheslav Paskal

Mail to: Baptist Church of Salvation 5831 Versage Dr. Charlotte, NC 28227
Pastor Veaceslav Paskal – 704-293-0100

PULSE INTERNATIONAL COMMUNITY ASSOCIATION

February 27, 2006

State Health Coordinating Council
c/o Floyd Cogley
Division of Facility Services
2714 Mail Service Center
Raleigh, North Carolina 27699-2714

Dear Committee Members,

This letter is in support of Personal Home Care of North Carolina, LLC petition to provide home health services. Personal Home Care of North Carolina plays an important and unusual role in and around the counties of Mecklenburg, Union, and Cabarrus. This personal care agency emerged in response to a unique problem and is providing very responsive services to a large community of new Americans that is difficult to serve.

Russian speaking immigrants from the former USSR republics of Russia, Ukraine, Belarus, Armenia, Azerbaijan, and other countries represent a large part of this population. We estimate that about 80,000 of Russian-speaking people are residing in this part of state now, and their numbers are growing. The communities began forming in the late 1980's, when the State of North Carolina started admission of refugees representing ethnic and religious minorities that were persecuted in their countries, grown immensely since collapse of the Soviet Union in 1990's, and continue to grow as people settle and re-unite with their families. Entire extended families are appearing in the area. This means that the parents, grandparents and older relatives come along with the younger ones. These immigrant communities represent people of multiple faiths and ethnic origins and several churches and congregations of multiple faiths have formed: Baptist, Pentecostal, Charismatic, Christian Orthodox, Armenian Episcopalian, Jewish, and others.

The older people do not speak English, or if they do, their vocabulary is very limited. They are legal immigrants and many are naturalized citizens. These individuals are often sick and disabled and entitled to Medicare and Medicaid services, but the language and cultural barriers make it difficult to happen. Family members in this community assign a person to stay with the older and infirm, but lay people cannot provide clinical services, and are not always able to act as clinical interpreters.
Personal Home Care of North Carolina was organized to meet needs of this population and. is the only agency that serves them. Personal Home Care of North Carolina staff members are bi-lingual in Russian and/or Ukrainian, have similar background and understand this culture. However, Personal Care of North Carolina is limited by licensure restrictions to the amount of service they can provide.

Elderly and disabled individuals with limited or non-existent English proficiency have difficulty getting home health agency because of the language and cultural barriers. Local agencies do not have Russian-speaking staff; therefore communication issues are paramount and care quality might become compromised. I believe that a policy permitting the state to add a home health agency to serve a cultural group this large makes sense and would be in the interest of making heath care accessible.

Our Pulse International Community Association has been fortunate to have access the limited services Personal Home Care of NC, LLC can provide for our members. Our members need more.

Please do not hesitate to call me should you have questions.

Regards,

Victor Nafatyuk
President

704-622-4488

Russian Business in Charlotte

A&A International Food
Alex Automotive
Alex Floors
Around the World
Auto Clinic Repair Inc.
Avsons
Carolina's International Realty
Charlotte Auto Sales
Charlotte Concrete Resurfacing
Distinctive Painting by Yuri
DS Engineering
Euro Surfaces
Europe Food Store
Ext./Int. Remodeling
E-Z Tax and Travel
First Star Auto Sales
Flara's Designs
G&G Inter - Clean
GP's Auto Sales & Body
Grandway
Home Tech of Lake Norman
JakiMed
Kalinka Cleaning Service
Kalinka Food Store
Karina Bail Bonds
Kirby & Kale
Lube Oil at Central Ave.
Making Computers Work
Meest
Nadia's Construction
New Construction Plumbing
North Carolina Medical Supplies, LLC
Panorama Charlotte, LLC
Papas Heating Cooling and Refrigeration Inc.
Pavel's Jewerly and Repair
PC Optima
Personal Home Care of NC, LLC
Piedmont Construction
Pineville Flowers
Pure Touch Janitorial & Cleaning Services
Salvage Auto Supplies
Samuel's Construction
Stockton Turner Mortgage Bankers
T/D Plumbing
Tatiana Chef To-Go
The Home Team Inspection
UL Excavating
Viking Hardwood Floors
VL Video Studio
Vlad's Tailor Shop

Russian Speaking Realtors in Charlotte

Victoria Kioroglo	Carolina Realty Advisors
Igor Korniyenko	Carolina's International Realty
Tatiana Zalinov	Carolina's International Realty
Sergey Dzyk	Corner Stone Realty
Victor Nafatyuk	Corner Stone Realty
Ella Pomerlyan	Keller Williams Realty
Olga Leggett	LGT Realty, Inc.
Ed Pershin	Mathers Realty
Elena Marx	Mathers Realty
Ivans Belovs	Mathers Realty
Ed Rosenbloom	Prudential Carolinas Realty
Lada Konstantinidi	Prudential Carolinas Realty
Elena Rudnitsky	Queen Realty
Aleksey Negru	Re/Max Elite Associates
Henry Zolotaryov	Re/Max Elite Associates
Luda Vaynshteyn	Re/Max Executive Realty
Nadia Boldt	Re/Max Executive Realty
Nina Hollander	Re/Max Executive Realty
Yuriy Vaynshteyn	Re/Max Executive Realty
Luba Nykyforuk	Realty1000 LLC
Nancy Muzichuk	Smith Realty, LLC

Russian Customer Service Representatives

Sergey Kioroglo	Latorre Insurance Group
Galina Livarchuk	Allegacy Federal Credit Union
Anya Pacyga	Allegacy Federal Credit Union
Victoria Novikova	Bank of America
Marina Kornev	SunTrust Mortgage

Russian Doctors

Kevin R. Ayvazyan, MD, NMD
Bruno Kaldre, DDS
Yulia Gorelik, DDS

Russian Churches in Charlotte, NC

First Slavic Baptist Church
7600 Plott Road
Charlotte, NC 28262

Slavic Baptist Church
13601 Idlewild Road
Matthews, NC 28105

Baptist Church of Salvation
4300 McKee Rd.
Charlotte 28270

Gospel Light
7835 Matthews-Mint Hill Road
Charlotte, N.C. 28212

Russian Pentecostal Church
6740 Albemarle Rd.
Charlotte, NC 28229

Spiritual Revival Center
116 N. Ames Street
Matthews 28105

Russian Orthodox Church of the Reigning Mother of God
1001 Queens Road
Charlotte, NC 28207

Churches with large attendance of Russians

St. Sarkis Armenian Apostolic Church
7000 Park Road
Charlotte, NC 28210

Temple Beth El
5101 Providence Road
Charlotte, NC 28226

Temple Israel
4901 Providence Road
Charlotte, NC 28226

Russian Business in Charlotte

A&A International Food
Alex Automotive
Alex Floors
Around the World
Auto Clinic Repair Inc.
Avsons
Carolina's International Realty
Charlotte Auto Sales
Charlotte Concrete Resurfacing
Distinctive Painting by Yuri
DS Engineering
Euro Surfaces
Europe Food Store
Ext./Int. Remodeling
E-Z Tax and Travel
First Star Auto Sales
Flara's Designs
G&G Inter - Clean
GP's Auto Sales & Body
Grandway
Home Tech of Lake Norman
JakiMed
Kalinka Cleaning Service
Kalinka Food Store
Karina Bail Bonds
Kirby & Kale
Lube Oil at Central Ave.
Making Computers Work
Meest
Nadia's Construction
New Construction Plumbing
North Carolina Medical Supplies, LLC
Panorama Charlotte, LLC
Papas Heating Cooling and Refrigeration Inc.
Pavel's Jewerly and Repair
PC Optima
Personal Home Care of NC, LLC
Piedmont Construction
Pineville Flowers
Pure Touch Janitorial & Cleaning Services
Salvage Auto Supplies
Samuel's Construction
Stockton Turner Mortgage Bankers
T/D Plumbing
Tatiana Chef To-Go
The Home Team Inspection
UL Excavating
Viking Hardwood Floors
VL Video Studio
Vlad's Tailor Shop

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Olga Leggett	LGT Realty, Inc.
Ed Pershin	Mathers Realty
Elena Marx	Mathers Realty
Ivans Belovs	Mathers Realty
Ed Rosenbloom	Prudential Carolinas Realty
Lada Konstantinidi	Prudential Carolinas Realty
Elena Rudnitsky	Queen Realty
Aleksey Negru	Re/Max Elite Associates
Henry Zolotaryov	Re/Max Elite Associates
Luda Vaynshteyn	Re/Max Executive Realty
Nadia Boldt	Re/Max Executive Realty
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Yuriy Vaynshteyn	Re/Max Executive Realty
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Anya Pacyga	Allegacy Federal Credit Union
Victoria Novikova	Bank of America
Marina Kornev	SunTrust Mortgage

Russian Doctors

Kevin R. Ayvazyan, MD, NMD
Bruno Kaldre, DDS
Yulia Gorelik, DDS

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Getting Real About EthniCity

Charlotte cuisine covers the globe, but do the locals care?

TRICIA CHILDRESS

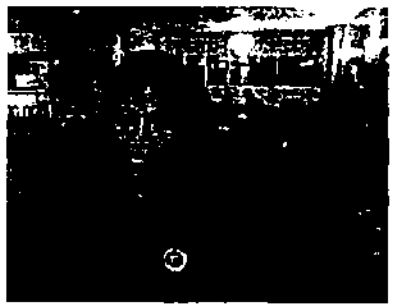
Next Generation Consulting, that now-notorious outfit that hired focus groups of "young professionals" to determine Charlotte's hipness factor, noted that one element that would make the Queen City "cool" is to have "authentic" ethnic restaurants, especially "authentic" ethnic restaurants in the city core. I'm going to assume for the moment that these "young professionals" did not mean putting in an Epnic (Disney's Epcot + ethnic) restaurant along the lines of a P.F. Chang's on the Square. I'll go with the hopeful premise that what they want are locally grown ethnic restaurants operating in the downtown environment. The study folk call this a "cultural amenity," since eating ethnic is a popular fad for grads.

But just how many ethnic restaurants does Charlotte actually have now? I asked Bill Hardister of the Mecklenburg County Health Department this question, since his department inspects all the food operations in the county. Unfortunately, his office does not stratify restaurants by type or size. On the MCHD list are 1,758 active food operators. This number takes in all the fast food franchises, including the 31 McDonald's and the 46 area Subways, the deli counters at the Harris Teeters, even the jail.

So although there is no official document with the precise number of ethnic restaurants, I culled through the list and arrived at approximately 300-plus locally owned and operated ethnic restaurants. I did not include the hundreds of Italian restaurants and pizzerias, local burrito-type chains such as Salsaritas, regional burrito chains such as Southwest Moe's, or locally grown gyro shops such as Showmars. Nor does this list include the growing number of ethnic bakeries or food markets. I tried to

RELATED INFO.

T.T. Chan of Cuisine Malaya
(credit: Radok)



Toi (Sukanya) B. Rogers of Thai Marlai
(credit: Radok)

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keep the list to actual ethnic eateries. In many cases, I made the distinction of ethnic from non-ethnic by calling the establishment and asking the owner if he, or she, considered the restaurant to be ethnic. Some non-ethnic eateries are owned by folks who have very ethnic sounding names.

I went further to break these 300-plus eateries into ethnic groups. The largest turned out to be the 110 area Chinese food vendors. Not all of these spots are restaurants. Some are take-out-only places while others are large, full-scale restaurants such as Wan Fu, Dragon Court, Shun Lee Palace and Baoding.

BY LINDA VESPA

Wine Ramblings
Stuff I can't keep bottled up
BY TAYLOR EASON

Wine List

Good Eats
Our critics' guide to recommended restaurants in Charlotte

Good Eats
Our critics' guide to recommended restaurants in Charlotte

Use this address for linking.

The next largest ethnic eatery group was Latino. In this category were about 90 Latino spots: 70 from Mexico, three from South America, four from El Salvador, and about 10 from the Caribbean islands of Jamaica, the Dominican Republic, Granada and Cuba.

Next are the "other" (non-Chinese) Asian spots. This list includes over 30 Japanese eateries, a few sushi-only places; 12 Vietnamese restaurants (one is a soup shop); 12 Thai restaurants; 11 Indian (two of these are south Indian vegetarian); two Korean (one of these is a small Japanese/Korean take out, while the other, Koryo, has been operating in Charlotte for 15 years); one Malaysian; and one Laotian.

Charlotte has four Middle Eastern eateries and one Persian restaurant (in addition to the Kabob House, Ali Baba take-out says it serves Persian, too). Two spots serve New Zealand cuisine and two serve African (non-Middle Eastern) cuisine. Of these, one serves Ethiopian exclusively, while the other serves Ethiopian and Eritrean. Regrettably, the West Africa restaurant, Katchikally, closed last year.

In addition to the plethora of Italian places — and Italian-American places — Charlotte is host to a handful of eateries from Europe, including France, Spain, England, Ireland and Germany. (If I've left out your restaurant, please call me: 704-522-8334, ext 136.)

Surprising, though, is the lack of a Russian or Eastern European style restaurant, given the burgeoning number of ex-pats from the former USSR and Yugoslavia who now call Charlotte home. There are a few ethnic markets: two Russian, one Russian/Armenian/Eastern European, and one Bosnian market.

Immigration and language of Ukrainians in the United States

by Dr. Oleh Wolowyna

Census data are the only reliable source of information on Ukrainians in the United States. The ancestry question allows us to estimate the number of persons who declared Ukrainian as their ancestry, and the question on language use at home allows us to calculate the percent who speak Ukrainian.

Given the relatively small size of the group, 0.3 percent of the total U.S. population in 2000, the Bureau of the Census provides only a few tabulations with data on Ukrainians. A sample of 5 percent of all the individual census records has been made available recently, and this allows us to answer the important question of what percent of all persons of Ukrainian ancestry speak Ukrainian at home, as well as many other questions.

The surprising, if not shocking, answer is that 12.7 percent of all persons who declared Ukrainian as their first or second ancestry (one can record one or two ancestries in the census), speak Ukrainian while 13.4 percent speak Russian. In other words, in the year 2000, among all Ukrainians in the United States the percent speaking Russian was higher than the percent speaking Ukrainian. In this article we will explain how and why this happened, and discuss some of the implications of this fact.

In order to understand this surprising finding, we need to look at the size and language composition of the different migration waves of Ukrainians to the United States. In Table 1 we present percentages of Ukrainian and Russian speakers for the whole group, the U.S.-born and the different migration waves, as reported in the 2000 and 1990 censuses. We see that the percent of Ukrainian speakers for the whole group (total column) increased slightly from 12.4 percent in 1990 to 12.7 percent in 2000, while the percent of Russian speakers increased from 2.2 percent in 1990 to 13.4 percent in 2000. This large increase in the percent of Russian speakers indicates that something unusual has happened between 1990 and 2000.

For the U.S.-born, the percent of Ukrainian speakers decreased from 6.6 percent in 1990 to 4.6 percent in 2000, while the percent of Russian speakers increased from 0.3 percent in 1990 to 0.7 percent in 2000. The percentages of Ukrainian and Russian speakers in the different migration waves provide further clues about this surprising result.

In 2000, more than half of persons who came to the U.S. before 1950 spoke Ukrainian, while only 4 percent spoke Russian. For the next migration period, 1950-1986, we see the beginnings of a trend; the percentage of Ukrainian speakers drops to 32 percent, while the percent of Russian speakers jumps to almost 26 percent.

Among the more recent migrants the percent of Russian speakers is much higher than the percent of Ukrainian speakers. For 1987-1990 the percent of Russian speakers is about three times the percent of Ukrainian speakers, while for the period 1991-2000 Russian speakers outnumber Ukrainian speakers by a factor of 1.6.

This trend was already captured in the 1990 census. It was not detected before, because the possibility of having a larger proportion of Russian than Ukrainian speakers among all persons of Ukrainian ancestry in the United States was frankly impossible to imagine at that time, and we did not look for it. The percentages of Ukrainian and Russian speakers for the before 1950 migrant wave observed in 1990 were similar to the percentages observed in 2000. For the 1950-1986 immigrants, the decline in Ukrainian speakers and the increase in Russian speakers are less pronounced than in 2000, but the beginning of a

similar pattern is there. The 1987-1990 immigrants show a higher percentage of Russian speakers than of Ukrainian speakers.

The percentages presented in Table 1 are complemented by their respective absolute numbers in Table 2. In the total column we see that, although the number of Ukrainian speakers increased from 88,000 in 1990 to 114,000 in 2000, the number of Russian speakers increased from 15,000 to 120,000 respectively. That is, among all persons of Ukrainian ancestry in the United States in the year 2000, the number of Russian speakers was slightly higher than the number of Ukrainian.

In 2000 among all pre-1950 immigrants about 9,000 speak Ukrainian and about 700 speak Russian. For the 1950-1986 migrants we have 20,000 speaking Ukrainian and 16,000 speaking Russian. Among immigrants arriving after 1986, the number of Russian speakers is much larger than the number of Ukrainian speakers. If we add the number of all Ukrainian speakers among the U.S.-born and immigrants before 1987, we have 59,000, while the number of Ukrainian speakers contributed by the fourth wave (1987-2000) is 55,000.

Thus, the recent immigrants contributed almost as many Ukrainian speakers as those among the U.S.-born and the previous immigration waves. On the other hand, the recent immigrants contributed 99,000 Russian speakers, compared to the 21,000 Russian speakers among U.S.-born and immigrants before 1987.

Significant differences are observed between the respective figures for 1990 and 2000. For the U.S.-born, the decrease among Ukrainian speakers (from 40,000 in 1990 to 30,000 in 2000) is probably mainly due to mortality, as a large proportion of Ukrainian speakers are elderly. One possible factor in the increase in Russian speakers among the U.S.-born (from 2,000 in 1990 to 4,600 in 2000) are the children of the large contingent of Russian speakers between 1986 and 2000 who were born in the United States. The same factor is likely at play for the immigrants for the pre-1950 and 1950-1986 immigrants.

The large differences between 1990 and 2000 in the numbers of Ukrainian and Russian speakers for the 1987-1990 immigrants are more puzzling. One hypothesis is that many of the Ukrainians recorded in the 2000 census were illegal migrants at the time of the 1990 census, and that by 2000 they had permanent status and/or felt more comfortable responding to the census.

The total number of persons of Ukrainian ancestry was 893,055 in 2000. The number of all immigrants was 253,400, and 56 percent of them arrived between 1991 and 2000. If we add the 1987-1990 immigrants (12.5 percent of all immigrants), we have a total of 68.5 percent of all immigrants belonging to the Fourth Wave. In absolute numbers there were 142,000 immigrants between 1991-2000, and 31,600 arrived between 1987 and 1990. This massive migration is bound to have significant effects on the Ukrainian group in the United States, and the larger proportion of Russian than Ukrainian speakers is just one of these effects.

These numbers are consistent with immigration statistics from Ukraine's Derzhkomstat (State Committee on Statistics) and the U.S. Immigration and Naturalization Service (INS). According to Derzhkomstat, between 1992 and 2000 about 111,000 migrated from Ukraine to the U.S. and, according to INS statistics, during the same period the number of immigrants born in Ukraine admitted to the United States was about 146,000. If we add the number of immigrants for the years 1990 and 1991, and consider the fact that some of the immigrants recorded by the census came from other countries than Ukraine (see Table 3 below), the census figures are consistent with both the Ukrainian and U.S. immigration statistics.

It is important to note that, according to Derzhkomstat statistics and the Jewish Demographic Yearbooks published in the United States, about 40 percent of all migrants from Ukraine during 1992-2000 were Jewish. Also a very high proportion of migrants from Ukraine during 1987-1991 were Jewish. Thus, it is

safe to assume that, of the 173,600 1987-2000 immigrants registered by the census, close to half are Jewish. Although they declared Ukrainian as their ancestry, it is highly unlikely that they are active in the Ukrainian community in the United States or may become active in the future.

Thus, in terms of potential for the Ukrainian community, the number of Fourth Wave immigrants is closer to 90,000. However, this still is more than the 85,000 immigrants estimated for the post World War II wave. It is also safe to assume that most Ukrainians who did not have a legal migrant status in the United States did not fill out the census form. Thus, if we add the illegal migrants to the estimated 90,000 ethnic Ukrainian immigrants registered by the census, we estimate that the total number of Fourth Wave ethnic Ukrainians in the U.S. is between 120,000 and 150,000.

As mentioned above, the 2000 census 5 percent Public Use Microdata Sample Tape allows us to study in depth the characteristics of the whole group, as well as of the different migration waves. The sample has complete census information on close to 43,000 persons of Ukrainian ancestry. It allows us to make cross-tabulations with any set of variables in the census form, select any subpopulation of the group, and thus produce a very large number of tabulations. Here we will analyze only one characteristic - country of birth - of the different migration waves, in order to get a better understanding of the Fourth Wave migrants. Table 3 presents the main countries of birth of immigrants by year of immigration for the Ukrainian- and Russian-speaking subpopulations.

Ukraine, Russia, Poland, the USSR, Germany and Canada capture about 95 percent of the countries of birth of all immigrants. Among Ukrainian speakers, 74 percent of the pre 1950 immigrants were born in Ukraine, 10 percent in Germany, 8 percent in Poland and 4 percent in Canada. It is interesting to observe that in this cohort of immigrants nobody declared Russia or the USSR as their country of birth, while among Russian speakers 14 percent said they were born in Russia and 9 percent declared the USSR as their country of birth.

Among the 1950-1986 Ukrainian speaking immigrants, the percent born in Ukraine declined to 58 percent, due to somewhat higher percentages born in Poland, Germany and Canada. Among Russian-speaking immigrants during the same period, 78 percent were born in Ukraine, 10 percent in Russia and 6 percent in the USSR.

The great majority of Fourth Wave immigrants were born in Ukraine. Among Ukrainian speakers this percentage was 88 percent for the 1987-1990 period and increased to 92 percent for the 1991-2000 period; the respective percentages for Russian speakers were 85 percent and 87 percent. The main difference between the Ukrainian and Russian speaking immigrants during 1987-2000 was that higher percentages of Russian than Ukrainian speakers were born in Russia and the USSR.

The surprising finding that there are more Russian than Ukrainian speakers among all persons of Ukrainian ancestry in the United States is due two factors: a) a large number of migrants to the United States during the last 13 years who consider themselves of Ukrainian ancestry; b) a high percentage of these migrants speak Russian at home. (The census language question reads "does this person speak a language other than English at home?"). We know that most of these migrants do speak Ukrainian, but many of them speak Russian at home and this is what the census measures. Thus Ukraine has been exporting to the United States part of its language problem, among many other things.

This result is likely to shock many members of our community and, hopefully, trigger an active debate. Some will consider this a tragedy, while others will accept this fact as part of our reality. This may be considered one of the negative consequence of the Fourth Wave migration, or a challenge to the community. The Fourth Wave migration has also had some positive effects that need to be considered. For example, if there were no new immigrants after 1986, the number of Ukrainian speakers would have dropped to 59,000 by the year 2000.

The Fourth Wave added to the community 55,000 persons who speak Ukrainian at home, and this is an

underestimate of all Ukrainian speakers, as we know that many of the persons who speak Russian at home speak perfect Ukrainian. Using the 5 percent sample we can determine the age-sex composition of both Ukrainian and Russian speakers, where they live, their marital status and family composition, level of education, income and occupation, as well as a number of housing characteristics.

Census data provide a unique opportunity to analyze in depth the characteristics of the Fourth Wave migrants and their potential impact on the Ukrainian community in the United States. The analysis of these data would require some resources. It is up to our community leaders to decide if they want to continue their work on the basis of perceptions, prejudices and misconceptions, or join the 21st century and use objective data as the basis for planning and decision making.

TABLE 1: Percent persons of Ukrainian ancestry who speak Ukrainian or Russian at home, by year of immigration: U.S. Census data, 2000 and 1990

			Years of Immigration (percent)			
Year/Language	Total	U.S. Born	< 1950	1950-86	1987-90	1991-00
2000:						
Ukrainian	12.7	4.6	52.2	32.0	23.8	33.3
Russian	13.4	0.7	4.0	25.8	66.2	55.0
1990:						
Ukrainian	12.4	6.6	57.8	42.9	35.0	
Russian	2.2	0.3	2.8	12.9	39.3	
Source: U.S. Bureau of the Census, 5% Public Use Microdata Sample Tape						

TABLE 2: Number of persons of Ukrainian ancestry who speak Ukrainian or Russian at home, by year of immigration: U.S. Census data, 2000 and 1990

			Years of Immigration			
Year/Language	Total	U.S. Born	< 1950	1950-86	1987-90	1991-00
2000:						
Ukrainian	113,691	29,736	9,098	20,016	7,525	47,316
Russian	120,463	4,625	692	16,143	20,909	78,094
1990:						
Ukrainian	87,788	40,272	16,889	26,543	4,084	
Russian	15,382	2,035	808	7,952	4,587	
Source: U.S. Bureau of the Census, 5% Public Use Microdata Sample Tape						

TABLE 3: Immigrants of Ukrainian ancestry by Ukrainian or Russian language spoken at home, year of immigration and selected countries of birth

	Years of Immigration (percentages)			
Language Spoken at				

Home/Country of Birth	< 1950	1950-86	1987-90	1991-200
Ukrainian:				
Ukraine	74.0	57.8	88.3	92.3
Russia	0.0	0.7	2.8	1.9
Poland	7.6	9.7	1.6	0.7
USSR	0.0	0.2	0.7	0.9
Germany	9.9	14.7	0.3	0.1
Canada	4.3	5.3	0.3	1.1
Russian:				
Ukraine	68.5	78.7	85.0	86.7
Russia	13.7	10.4	7.0	5.8
Poland	0.0	0.3	0.2	0.0
USSR	8.7	6.4	4.6	2.3
Germany	3.5	0.8	0.1	0.2
Canada	2.6	0.0	0.0	0.0
Tot. No. of Immigrants	17,423	62,484	31,592	141,934
Source: U.S. Bureau of the Census, 5% Public Use Microdata Sample Tape				

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